COOS COUNTY FAMILY HEALTH SERVICES, INC.

Consent For Services

DOS:

Patient Name: DOB:

I voluntarily consent to receive services for myself (or) my child from Coos County Family Health Services. I understand that these services may include routine, preventive health care, and illness management. I understand that I will be kept informed of my (or) my child's medical condition(s) and treatment plan(s). I acknowledge that Coos County Family Health Services maintains medical information in various formats that include, but not limited to computer data, paper, digital, and other images.

I have received an explanation of the services which I (or) my child will receive and understand that I have the right to ask questions and to refuse any service which I do not want.

I authorize CCFHS to release medical and billing information to reference laboratories, including but not limited to Androscoggin Valley Hospital. I understand I may receive a bill directly from the reference laboratory for services provided.

The Patient's Bill of Rights is posted in the waiting room and a copy is available upon request.

I request that payment of authorized Medicare/Other Insurance company benefits be made on my behalf to Coos County Family Health Services for services furnished me by the party/physician who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-2812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits apply.

I authorize release of medical or other pertinent information about me to the Social Security Administration/Health Care Financing Administration as well as any other third party payor for claim adjudication. I permit a copy of this authorization to be used in place of the original.

I authorize Coos County Family Health Services to release billing information and other demographic information given on this form to subsequent care givers and physicians covering for Coos County Family Health Services.

May we discuss your health information and billing information with a family member, spouse, or other person involved in your care or payment for your treatment or services rendered? □ Yes □ No

If yes, Individuals Name: _____

Phone Number _____

_____ Date: _____

Signature of Patient (or) Parent (or) Legal Guardian

_____ Date: _____

Staff Member

(Consent - 3/04)
(Rev. 1/06, 6/08, 6/09, 3/13)